

**COLONEL KENTON HARTMAN, USAF  
ARMED FORCES INSTITUTE OF PATHOLOGY  
ORAL HISTORY PROGRAM**

INTERVIEWER: Charles Stuart Kennedy

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*Q: Colonel, I'd like to get a little about your background. I wonder, could we start sort of at the beginning, when and where you were born and a bit about your family and early education, please.*

**COL. HARTMAN:** Yes, sir, I'm a native of Iowa, a Hawkeye, so to speak. I was born August 13, 1938, in a small town in Iowa. I happened to be born in my grandmother's house and the house my mother grew up in. This little town of Missouri Valley, Iowa, is fairly close to the Missouri River and is currently experiencing some of the floods that have been going on. Following that, I grew up primarily, for the first five years, in Iowa and Nebraska, and then moved to Indiana.

*Q: Were you of a farming family?*

**COL. HARTMAN:** My father worked for the Rural Electrification Association, bringing electricity to some of the farms in the Midwest and Arkansas. And then he got posted back in Indiana and joined a public service company, an electrical supplier again. From the time of about the third grade until I graduated from college, I lived in Indiana. My parents--Mother didn't work; Father did work, mostly as an electrician, and then, later on, as a specialist in automobiles, a shop foreman for a large GM dealership. I went to high school in a small town, called Versailles High School. Moved to a little town of Milan, of basketball fame. If you happen to be a Hoosier, basketball is everything, especially in the spring in Indiana. A couple of movies have been made about the little school where I lived.

*Q: The Hoosiers?*

**COL. HARTMAN:** Yes, *The Hoosiers*. In 1954, this little tiny school, in a town of about 2,000 population, happened to win the state championship. In Indiana, all classes of school are thrown together; you don't segregate by size of the school. So, for a little town with about 150 people in the high school to win a state basketball championship, this was the Cinderella team of the century. And they're still making movies and doing interviews.

It so happens my brother-in-law happened to be one of the starting forwards.

*Q: Oh, my goodness.*

**COL. HARTMAN:** A fellow by the name of Bob Engle. He lives up in Kalamazoo, and last summer, because the basketball story *Hoosiers*, the movie, was out a couple of years ago, they

came out to interview him. They knew he'd been a player. He had a basketball goal in his backyard, and he hadn't shot a basket in years, but for the purposes of the interview, he made about ten shots straight, his famous old jumpshot. So he felt pretty good about that, and he got on the local TV and in the paper.

I attended college as an undergraduate in Bloomington, Indiana, Indiana University, from 1956 until 1960. Graduated with a Bachelor of Arts degree in science, primarily zoology. Went on to dental school at Indiana University School of Dentistry from 1960 to 1964 and graduated with high honors.

*Q: I'd like to now go back just a bit. What attracted you towards dentistry? Had anyone in your family been a dentist?*

**COL. HARTMAN:** No. In fact, there had never been a health professional of any type in my family. But I married in 1960, just prior to going to dental school, and my father-in-law happened to be a physician. I had always planned on becoming a chemist, perhaps working in the pharmaceutical industry. But he said, "No, you don't want to do that. You'll never make any money. Why don't you go to dental school or medical school." Well, at that point, I'd taken all the prerequisites--the physics and the language and the math and such--and so I said, "Well, dentistry seems pretty interesting."

I took the proficiency test. The American Dental Association, which conducted the proficiency test, would send you a little kit to practice on, and then, on a given date, you would go to a center and they would have you carve little things out of plaster blocks. Well, I practiced trying to carve teeth. I had a terrible time trying to carve teeth out of a hard plaster block. The plaster they used was a special kind of soft plaster that was nice to carve. So when we took the examination, I went there with the thought that we're going to carve a tooth. What else would they have prospective dental students carve? Well, it wasn't a tooth. It was something that looked like a miniature Coke bottle. And you had to put the grooves in it, and you had to detail it. They gave you about a half a day to do that, and then another half a day to take some written tests. Well, I didn't think the object that I'd finished with looked like the model that they'd shown us, but it was good enough, and I was able to enter dental school.

*Q: You went to dental school where?*

**COL. HARTMAN:** Indiana University School of Dentistry, at the medical center campus, which is located in Indianapolis.

*Q: How long was the training there?*

**COL. HARTMAN:** Four, very vigorous, years of training.

I worked also as a student researcher for the Department of Biochemistry. One of my interesting jobs as a student researcher the first year was to work for a fellow by the name of Dr. Joe Mueller, who actually invented Crest toothpaste for Procter & Gamble Company. I got paid \$1.25-an-hour, to start, and we would work after hours and on weekends. And my job at that

time was to brush little rats' teeth with various fluoride solutions. It's kind of interesting, how do you get a rat to open its mouth so you can brush its teeth? We were able to accomplish that by taking a little wire that was V-shaped, putting the rat's mouth over it, and then pushing it, and you would just expand the jaws. And then you'd take your little miniature toothbrushes and dip the solution on the rat's teeth. Well, sometimes these rats would slip off of the wire, the V that you had, and they, of course, would bite you. We didn't wear gloves or anything, so I suffered a lot of rat bites. At the end of the experimental period, we, of course, would sacrifice thousands and thousands of these rats. Today, with the SPCA, you couldn't get by with doing that type of research. It was, I would say, rather brutal then. I began to feel like the Adolf Eichmann of the rat world, because we were sacrificing too many of these.

I then moved into the Department of Oral Pathology, in my second year of dental school, for after-hours work. I knew some friends who were graduate students in oral path., and that appealed to me a lot more than working with fluoride and rats' teeth. I got to do some very interesting basic research with Dr. William G. Shafer, who was the mentor for oral pathology. He tried to convince me, at the point of graduation, to enter graduate school and become a specialist in oral path.

At that time, I really didn't feel like I was ready to commit to a specialty; I wanted to try doing some general dentistry. So I did that, in the Air Force. I entered the Air Force June 30, 1964. I became a dental intern, what you would call a rotating dental intern. We spent about half the time in hospital departments, the other half of the time in dental clinics. And we still train people in this fashion today.

*Q: Where were you serving?*

**COL. HARTMAN:** I was at Chanute Air Force Base, Illinois. And that's one of the recent bases that's been on the base closure list; it was closed a couple of weeks ago.

*Q: What type of base was that?*

**COL. HARTMAN:** It was called a technical training center [Air Training Command]. They taught jet-engine mechanics, electronics, weather, and that sort of thing. But they had a fair-sized medical center, about a 300-some-bed hospital, and they had a few residency programs, like the dental rotating internship. There were four of us in our class. Two of us are still on active duty and have a mandatory retirement in '94. My other classmate happens to be an oral surgeon, and he specialized at about the same time I did.

During the dental internship, the thought is that you get exposure to a number of specialties. It makes you an additionally trained general dentist; you're not really a specialist, but have a little additional knowledge. And then they would send you out to small clinics, where you sort of acted as the quasi-specialist.

Following completion of my internship, I was sent to Malmstrom Air Force Base, in Great Falls, Montana. We had ten dental officers at the time, and I was the only person who had an iota of graduate training. So I became the jack-of-all-trades there. I had quite an interesting, thriving practice in oral surgery and periodontics, and enjoyed it very much. Now that was a

SAC (Strategic Air Command) base. We had a number of fighter aircraft. That base is still open today. It's a large missile base now instead of being primarily a missile-fighter base.

I stayed there until November of '67, and then I was called upon to go to Southeast Asia. I reported to a small base in Thailand called Takhli Royal Thai Air Base, which was about 130 miles due north of Bangkok. It was in the central plains, the rice paddy area.

I served a year there until December of '68.

*Q: It was what, mainly for fighter-bombers?*

**COL. HARTMAN:** Takhli was a fighter-bomber base. We had a number of what are called "Thuds", F-105s. They could carry quite a bit of ordnance. Their frequent targets were the Ho Chi Minh Trail and downtown Hanoi. Lost a lot of people; lost a lot of roommates. Very hot climate. Wonderful people. I think that was probably the most educational assignment I've ever had. I terrifically enjoyed myself with the Thai people. And I've gone back since, to try to find old friends, but, of course, it'd been too long.

After my assignment in Thailand, I applied for graduate school. I'd been a general practitioner now from 1964 till 1968, and I thought, well, I'd had enough of general practice. I couldn't do this the rest of my life; it's very hard work. So I applied to graduate school, again back at Indiana University School of Dentistry, and was accepted into the graduate class the summer of 1969.

But since I ended my Southeast Asia tour in mid-year, Christmas of '68, essentially, they had to park me somewhere for six months before grad. school started. So they sent me to Eglin Air Force Base, Florida, in January of '69, and I left there in June of '69 to go to grad. school in July of '69.

*Q: Grad. school comprised what?*

**COL. HARTMAN:** This comprised thirty hours of various requirement courses in your specialty, plus some other basic sciences. You repeated some of your anatomy, physiology, biochem., basic pathology courses, advanced pathology courses. Very intense. In fact, Indiana University had the premier program in oral pathology training, of which Dr. William Shafer was the chairman. His boys, so to speak, that were turned out of his training program have become some of the real greats in oral pathology, and many of them are in very prestigious positions still today.

*Q: As a layman and for somebody who might not be too familiar, what does oral pathology mean?*

**COL. HARTMAN:** You become a specialist in diagnosing diseases of the oral cavity and the perioral adjacent regions. With your dental background, of course, you're pretty much an expert in doing surface soft tissue examinations. But the oral pathology aspect of it, you've had additional training in the lymphatics and the vascular supply and the nerve supply and actual cellular mechanisms, basic mechanisms of tumor growth, metastasis. And you learn the

terminology of general pathology, plus you begin to specialize in the terminology of the oral region per se. Now there's some crossover. For the posterior part of the oral cavity, you then get into the vicinity of what comprises otolaryngic, ENT-type, pathology. We have a lot of interchange. Basically, the most-common benign lesions of the oral cavity are pretty well known to most general dentists. However, there are a number of things that the average dentist is unable to diagnose, and he needs the expertise of the specialist to make, especially, the microscopic diagnoses. Every dental student gets some training in microscopic interpretation, but it's not nearly enough to qualify him to be a pathologist.

So we were trained for a period of five years. The residency program I had consisted of two years at Indiana University, and then three years here at the AFIP to finalize the five full years of graduate training.

*Q: So you came here in...*

**COL. HARTMAN:** I finished the graduate program in July of '71, and reported here later on in July of '71.

*Q: Had you had any connection with or knowledge of the AFIP before you got here?*

**COL. HARTMAN:** Oh, yes, I certainly did. My program at Indiana, they had corresponded over the years with AFIP. Dr. Shafer had been here and taught many of the courses and had sent many cases back and forth on consultation. So we knew a lot about AFIP before we ever came here.

And, of course, we came with the knowledge that he had never had any of his people flunk the Boards, so when you came here, he wanted you prepared.

Of course, nobody can prepare you for the types of cases that the AFIP has. You've heard this before, but it truly is a unique institution. You can come from the best program in the world, but you're never quite prepared for what you face when you arrive here. The types of diseases, abnormalities, tumors, et cetera, that you're faced with here in the span of a week, you would probably spend the better part of a year before you even saw one of these cases. And during one week, you might see several examples of a very rare entity. There's no other facility that gets the type of cases, in the numbers, that this place gets.

So, in a very short period of time, you can learn so much about the normal and the abnormal that, if you stay here too long, I've always been of the opinion you get a little warped, because this is not the true world of pathology. You get sort of jaundiced into thinking that everything you look at is an oddball type of lesion. So I've always been of the opinion that probably four to six years is the optimum length for a military assignment at AFIP. After that, if you want to stay in general surgical pathology, it's probably best that you move on. If you want to stay research oriented, publication oriented, or more academic, this is a marvelous place to spend your career.

*Q: You arrived as sort of the new boy in oral pathology. How did they use you?*

**COL. HARTMAN:** We had a large department then; there were twelve of us here in the department. We were bulging at the seams. As residents, of course, you're expected to take the cases. You start with the routine, the easier cases sometimes, and you write them up and you take them to your mentors for diagnosis confirmation. And they rewrite your letters to get them into the style that they like. And you eat a lot of chaff while you're a resident. That's just the way the system works. But it's excellent training for you. They make you start preparing lectures so you'll become familiar with teaching, because, as you know, the missions here require you to not only do consultation and some research, but there's a lot of education required of you.

*Q: As fairly new in this particular field, to whom would you be lecturing?*

**COL. HARTMAN:** We would start with other dental residents. For example, at Andrews Air Force Base, Maryland, we had a small dental residency program, and we would be expected to teach their residents. Every month, we'd have an afternoon session. And I might be assigned metabolic diseases of bone. That would require many hours of library preparation, slide making, and boning up [pun intended]. So that when my turn for the three-hour lecture came, I'd done an awful lot of work and I learned a lot in the preparation. We didn't lecture in the large annual courses, as residents, until we were pretty much a senior resident. So, by the end of the third year here, we were fairly experienced, and they trusted us to do lecturing of all types at that point. We would go down to the local universities, Georgetown University School of Dentistry and Howard University School of Dentistry, and lecture to the dental students and work with the graduate students. And we would get invitations from local dental societies, and sometimes universities out of town, to go make presentations. The more senior you became, of course, the more invitations that were expected.

*Q: During this time, the early '70s, were there any types of problems in oral pathology that were showing up then that were sort of indicative of the era?*

**COL. HARTMAN:** Yes. That's a very good question, Mr. Kennedy. During the Vietnam era (and, of course, in the early '70s, Vietnam was still going on quite actively), by chance, we happened to start getting a number of lesions, which I had seen at Indiana before I came here, of very fiery red gingiva, gum tissues that were swollen, edematous, painful, much more often seen in young females than males. And we were flooded with a number of these cases. It was called plasma-cell gingivitis, because histologically, with your microscope, you saw these mass sheets of plasma cells and a sprinkling of other types of inflammatory cells. And for years, people had wondered (this had been going on since about the mid-60s) why are we suddenly seeing a rash of what looks like some type of allergic gingivitis? Well, the Wrigley Chewing Gum Company had normally obtained a flavoring agent, like for their spearmint gum, that came out of Southeast Asia. But during the Vietnam War, their access to that flavoring agent was interrupted, so they had substituted another type of flavoring agent. I don't know where they got it, but it was causing a lot of gingival problems in people who were susceptible to this allergen, whatever it was. I have not seen a case of so-called plasma-cell gingivitis in many years now.

*Q: Was Wrigley informed of their problem?*

**COL. HARTMAN:** Yes, the dental community let them know about it, and eventually they changed the formulation of the flavoring agent. The problem didn't disappear completely, because there's more than one allergen. Many foodstuffs, mouthwashes, lozenges, et cetera, might use the same agent or other agents that would cause an allergic response. But the incidence of the plasma-cell gingivitis decreased tremendously right after the Vietnam War ended. So that was an interesting phenomenon of the times that we saw.

*Q: Here you are, a director of the Institute, but at that time, how'd you feel the place was run, administered, and all that when you came here?*

**COL. HARTMAN:** Well, you have to remember that this was a different era for the military. We had a lot more facilities, in terms of people support for the infrastructure, than we have now. We used to have administrators in many of the departments, which we no longer have the luxury of having today. We had many more enlisted people serving as extra helping hands in departments. I know, in the Department of Oral Path., we always had an enlisted Navy man or an Army man to help us run errands. The infrastructure, because of budget, primarily, and personnel authorization, has just gradually reached the point now where we're fairly critical in some departments. We don't have enough help to keep the secretarial staff going. And the caliber of the people sometimes is not what you saw years ago. We just had more of everything back then. We had better building maintenance. I don't know that we had any more professional staff; I think that's stayed fairly constant. But the support staff has really decreased in numbers.

*Q: And in effectiveness, I take it.*

**COL. HARTMAN:** Yes.

*Q: How about the professional staff? Was there much of a difference between the doctors that you could get at that point and, say, you can get now?*

**COL. HARTMAN:** In terms of recruiting for the military, during the draft and the pony express days, you got some fantastic specialists. It wasn't a problem. But after the Vietnam War ended, as far as financial remuneration, the difference was so great between serving in government and going out and rebuilding a civilian community practice, that we began to see more and more problems in recruiting, especially various types of specialists. In dentistry, we had trouble recruiting orthodontists, for example. We had trouble recruiting oral surgeons. We've never had problems recruiting oral pathologists. They're kind of at the lower edge of the pay scale in universities and such. Once an oral pathologist joined, he usually stayed for quite a period. But we had trouble recruiting many, many of the medical specialists, the radiologists, obstetricians, gynecologists, thoracic surgeons, that sort of thing. And that continues today, of course.

But, in spite of all that, it's still surprising, the military, with its educational programs, if they'll send you to medical school, and you go through the HPSP (Health Professional

Scholarship Program), a surprising number of people will still sign up for that program. That's the best way I know of in order to send somebody to medical school. And then they have obligated payback time. During that payback time, many people will take a residency. It might be three years, it might be six years, of graduate training. They get fantastic training, at the courtesy of the military. But these people are functioning and they're treating patients. It's a good deal for the government, and it's an excellent deal for the candidate. So, with that program, they've been able to maintain most of their specialty requirements, in most areas, not all areas.

*Q: Again going back to the early '70s, how did you find the referral system in oral pathology?*

**COL. HARTMAN:** Very similar to what it is today. I think, back then, we tended to get a few more cases from dental colleagues in universities. I think we probably have picked up a few more physician referrals than we had back then. It's branched out. People have learned more about oral path., and they've gotten into other areas of health care. People have decided, "Well, gee, these people are very reliable for oral lesions. Let's send it to them instead of, say, to the general pathologist locally or to an ENT pathologist." So our specialty area has grown in terms of knowledge by other health professionals.

The in-house referral system, where we would consult with other departments on cases, or they would consult with us, has remained essentially unchanged. One of the real strengths of training in this institution was the in-house consultation system. We would fill out what was known back then as a pink sheet (it was actually a pink sheet, had a form number), and that was the interdepartmental consultation request. If our mentors and the departments said, "Well, why don't you walk this down to Soft Tissue Pathology," at that point, we may have had the opportunity to sit at a double-headed microscope with the likes of Dr. Helwig or Dr. Enzinger. And for a young pathologist to have that experience, of course, it was just a tremendous teaching experience. It really vitalized you and made you want to do even better and progress in your subspecialty area.

*Q: What happens if your mentors and you run across a problem that really keeps puzzling you? Is there any sort of higher court of appeal? Are there people you can call in, farm out to, or anything like that?*

**COL. HARTMAN:** We would do that, and still do today. You might cut multiple sections on a difficult case and send it out to your colleagues at various universities or other military centers, then aggregate the opinions, and then send out a letter that reflects what the majority opinion was.

But, basically, with the amount of training the people in this institution have had, if they don't recognize it here, no other center will recognize it either.

There's still quite a limitation, as you probably know, to interpretation by light microscopy and our special stains. Many people over the years have made the saying that special stains only color what you don't know a different color. So the special stains, it's been interesting to watch the progress of what immunochemistry and various histochemical techniques have done.



All of these new things that came along were going to revolutionize the way that people practiced pathology. None of them has done it yet. However, we're on the verge now of some fantastic new diagnostic probes in molecular biology. And I think the time has arrived now. Within the next ten years, I really do believe that molecular biology, getting down on a genetic chromosomal gene basis, you're going to see tremendous strides in not just pathology, but all of clinical medicine. It's really going to revolutionize things.

*Q: How well is the AFIP equipped to get ready for this?*

**COL. HARTMAN:** We're doing nicely. Of course, this requires fair investments of people as well as equipment. We do have a number of very good molecular biology labs already in the Institute. We are already the world's leader in DNA human identification efforts. Our laboratories here were established just two and a half years ago, and the technology that our people are developing in DNA sequencing and mapping is already in the forefront of DNA technology for human-remains identification.

Now, obviously, there are many, many areas of DNA that are being looked at worldwide, but one area of particular interest to us relates to human-remains identification, because of our work with the mass disasters and the medical examiner system here. So we're into a new technology called mitochondrial DNA. That's a technology that right now only about four laboratories in the world are using, and of those, we're probably the leading laboratory.

We have been working with sets of bones, a few remains that were left over from the Vietnam era. Some of these bones, of course, were leached out; they were stored in unfavorable conditions, depending on the soil they were buried in. Some of these bones have been just unearthed from crash sites of aircraft. So we have been successful in helping the Army's central identification lab in Hawaii with making a few identifications. It's very tedious, very time consuming.

We're gearing up for a briefing Thursday afternoon, as a matter of fact, to make a proposal to the Army to try to help us expand this effort. We cannot do more than we're currently doing. They would like for us to do a lot more, but it's going to require more resources. If we can give families some comfort in knowing that the remains are those of their loved ones, this is a tremendous human service that the institution can provide.

*Q: Well, this, of course, is one of the fields where dentistry is often very important, in identifying people, if you have enough remains. And so I suppose this sort of falls within the dental bailiwick.*

**COL. HARTMAN:** That's correct, it does. Yes, we started doing small numbers of cases to assist the FBI. I think our first affiliation with the FBI was in the early '70s. I can recall, right after I came here in '71, we would work on cases with the medical examiner people and forensic pathology in the Institute.

We didn't get an opportunity to do a so-called mass disaster until early December of 1974, right after Thanksgiving holiday. A TWA flight crashed on approach to Dulles Airport, and we were deployed out to a small schoolhouse in Virginia. This TWA was a 707; it had a lot of

people onboard. I think we helped identify some 94 bodies, as I recall, and most of those were done by fingerprint and/or dental identification. So we got our feet wet in 1974. That involved many pathologists and dentists within the Institute plus a number of FBI and county officials and other medical examiner troops. So it was a good learning experience for the AFIP.

And then, in March of 1977, the Tenerife jumbo-jet disaster occurred over the Canary Islands.

*Q: Two planes collided, I believe.*

**COL. HARTMAN:** As you recall, two 747s hit each other on the ground; a KLM and a Pan American 747 had quite a collision. Bob Brannon, another Air Force oral pathologist, who was still a resident, and I were sent over to the Canary Islands as part of a team. We were accompanied by a civilian forensic dentist by the name of Lowell Levine, and Art Goldman, another civilian forensic dentist, both from New York. We went as a team of four dentists, with a number of people from the Institute, to the Canary Islands to see the crash site. The officials at the Canary Islands, in Tenerife, would not allow us access to the bodies. Somehow the Dutch government was able to get in the day before we got there. They did their dental IDs, and left the scene, knowing pretty much who had been onboard the KLM 747. We had quite a bit of political maneuvering to do, because Spanish law said that 48 hours after death, remains have to be buried. Well, we got there the day after the crash, and the 48-hour period had come, and they really wanted to inter the remains. Our State Department had to intervene. As I said, we were not given access to the bodies. We were really treated kind of shabbily. It made an impact on me, realizing that Americans can't push everybody around that they'd like to. We were on foreign soil, and you lived by their rule. So we had to come back, after spending four days at Tenerife.

The most exciting event that occurred was the ride to Tenerife. They had put a bomb in a flower shop in the airport at a neighboring island. This bomb went off and they closed the airport and had to temporarily use Tenerife for the overflow. It was a terrorist-type of bomb. Since they closed the airport, these aircraft had to land at Tenerife airport, about a 20-minute flight away. The crash occurred when they reopened the bombed airport as the planes got in line in preparation to leave Tenerife. These people were on holiday. They were flying somewhere to get on a cruise; I don't remember what the port of call was. But since the airport at Tenerife was closed due to the crash, , we couldn't fly in there. There weren't enough helicopters to ferry people over, except for officials.

So we had to ride this stupid boat. I have never been seasick in my life, but this was the closest I came to it. We got on some type of transport that must have had a round hull, just like a bathtub. It couldn't have had a keel of any sort. And we set off across on this four-hour journey.

It wasn't that many miles, but every mile was misery, because about 20 minutes out of the port, on the way to Tenerife, people started getting seasick. And you could watch them; they were rolling with the boat, and pretty soon, they were all going outside and heaving over the side. Well, pretty soon, they couldn't make it outside; they were heaving in the dining room. And we're sitting in the dining room, hanging on to the table for dear life, just trying to stabilize ourselves. Well, I remember going to the men's rest room, and there was vomitus four inches deep, just sloshing back and forth in this little narrow bathroom. Worst trip I've ever been on in

my life. I remember that more about Tenerife than anything else.

So then, when we came back here, they said, well, we've got to identify the American remains. And remember, we're military, and these are civilians. But there's a public law that allows the civilian authorities to request assistance of the federal government; meaning they can have the military participate in some of these disasters. So we did that at Dover AFB Port Mortuary in Dover, Delaware.

And this is where one of the former chairmen of the Department of Oral Path. comes in-- Col. Southern P. Hooker. He was the chairman from 1976 to 1979. And Southern P. was trained as an oral surgeon. He entered the Army during World War II as a pilot; he became a B-25 pilot.

After the war, he went to dental school. And then, towards the end of his Air Force career, he finally got sent here to become the chairman, in 1976. Southern was probably the most unforgettable oral pathologist I have ever met. He had great ability to take extremely complex problems and boil them down to a very simple solution. He was supremely organized. His problem was that he could do things so quickly, that would take the rest of us many days to accomplish, that he'd be sitting around twiddling his thumbs, sitting in my office and bothering me. I couldn't get him out of the office enough times. But I learned a lot from that man.

And what we learned about mass-disaster dental identification really came from Southern P. Hooker's efforts. He took the dental disaster team at Dover and organized them into very specific units. People knew what their jobs were. He'd rotate the positions of people. And we gained a lot more experience in doing Tenerife than we did with the TWA disaster in 1974. And based upon what Col. Hooker's identification organization amounted to, that gave us the framework for what we still use today, pretty much, when they go to Dover to do mass-disaster IDs.

*Q: I might mention, 'Dover' is Dover Air Force Base, in Delaware.*

**COL. HARTMAN:** Yes, the port mortuary is at Dover Air Force Base. That's an exclusive federal jurisdiction. Remains can be flown in there without any problems with local or state officials. That's why we have elected to do most of these stagings at Dover.

Well, after Tenerife, things became quiet. Then Jonestown came along in November of 1978.

*Q: I was going to ask about Jonestown. Could you explain what Jonestown was.*

**COL. HARTMAN:** Well, if you remember, we had a religious sect of people that left the United States. I think they had a large temple in California. And, because of religious persecution, Reverend James Jones, who also happened to be Hoosier, by the way, was a rather evangelistic-style preacher who developed a cult. He may not have liked it being called a cult, but that's essentially what these people appeared to be. He moved the colony down to Guyana and started his own little colony named Jonestown. As I recall, these people were totally self-sufficient: they had medical, they had nursing, they had farmers, they had whatever it took to become self-sufficient. They grew their own food. He collected mass dollars, by the trunkful, of Social Security checks, which they found after the disaster. They found a trunkful of passports

and many stacks of Social Security checks and other monies that belonged to the people in the colony. But, of course, they never got to spend any of that. If it had not been for the finding of this box of passports that was in Rev. Jones's quarters, we probably would never have made very many identifications, because this was largely an indigent group of people. A large number of blacks were associated with this church, many of whom were elderly or who had never had any dental care. So dental records were fairly sparse for these 913 people. And to complicate the situation further, a number of these victims were small children, and they, of course, had never had any dental care.

Now something similar has happened recently with the disaster in Waco, Texas, with the Davidians. There were also a number of children in that Davidian group who had never been out of the compound and never seen a dentist. As you know, those victims were burned up, and identification has become a problem with that. And we will be probably assisting the FBI in doing some of the Waco IDs by DNA now.

But to get back to Jonestown, those 913 sets of remains deteriorated very rapidly in that tropical climate. So removing the bodies and bringing them back to Dover, to the port mortuary again, was a massive relocation effort. It took a lot of Air Force personnel and Army people to recover the bodies and transport them up here. The remains were in just unbelievable degenerative condition. They had completely skeletonized some sets of remains. Ordinarily, given a normal summer day of, say, 75 or 80 degrees, you might expect it would take two or three weeks or perhaps even longer for things to really deteriorate. But these remains, in the period of one week, you could take a skull, for example, and just literally wipe the flesh right off of it. It had turned to a paste-like compound; it looked like mud. The odor was just horrendous. There was no way to control the odor. People working with this disaster not only had the overwhelming psychologic difficulty of facing that many dead people, but the condition of the remains... It's bad enough to do identifications on freshly killed remains, but to see remains in a state like this, it was psychologically very difficult for some of these people to work on this identification effort. Even today, there's nothing else that even touches the largeness of what Jonestown constituted.

The people were so frustrated with the mortuary, because of the odors and the paste, and we were slipping and sliding all over the floors. And the maggots became a huge problem; there were maggots just crawling out of all of these bodies. And out of frustration, some people went out and bought 50-pound bags of slaked lime, the type you used to put in the outdoor johns, and they would just throw it on a body. Well, they didn't do this except for a couple of bodies, and we found out about it and put a stop to it, because it's been our policy, we always do full-body X-rays as well as dental X-rays on every set of remains. That slaked lime just wiped out the radiographic image; you couldn't take X-rays of these bodies. So they stopped doing that. Other people took fuel oil from the diesel engines, and poured fuel oil over them, to try to keep the maggot population down. Nothing worked. Eventually, people became conditioned after a couple of days, and just literally gutted it out and were able to complete the operation.

*Q: Oh, boy, so this is the nice clean work of dentistry.*

**COL. HARTMAN:** Well, it affected everybody: the technicians, the dentists, the forensic

pathologists, the medical examiners. Everybody in the Institute gets involved in these mass disasters. We have taken a number of our people up there and kept them for long periods of time. It took about ten or twelve weeks, as I recall, to do the Jonestown thing. You do most of these identifications in the first week. After that, you can taper-down your work force and keep a skeleton crew [pun intended?]. You're waiting usually on records to arrive. And in this case, there just weren't a lot of records that were available. So out of the 913, I think more than half were identified.

Things remained quiet after November of '78. Well, there are always small-aircraft accident investigations that people participate in around here. But there were no more mass disasters until Beirut, Lebanon, the Marine disaster in October of 1983. That was one that was fought over. The people in Europe wanted to keep the 246 sets of remains.

*Q: A suicide bomber blew up the Marine barracks in Beirut.*

**COL. HARTMAN:** That's right. A suicide bomber had a truck loaded with explosives. He jumped over a large pipe to gain entrance to the Marine barracks. The guard had no bullets; nobody could get this guy. He came in very early in the morning, somewhere, I think, around six o'clock, and all the Marines were still sleeping. He got his truck in the internal portion of this compound. The explosives went off, and it caused a collapse. The building just literally collapsed inward, into this large atrium-like area. And the Marines were trapped in there. Many of them were alive, but they could not be extracted because of the masonry that had fallen on them.

As I said, there was some fight over who would do the identification there. And in Europe, the on-scene commander won out. He said, "These people are going to be identified in Europe," and he kept the remains over there. He got his own team together; a lot of people from Wiesbaden, at the large Air Force hospital there, were assembled. They brought the remains to a little air base called Rhein Main, on the other side of Frankfurt Airport. A large number of tents had just been put up for an exercise called Reforger, which is an annual exercise over there. The tent had wooden floors, and they hadn't torn it down yet. So they left a huge tent in place, and that's where the morgue was established.

I happened to be over there on vacation at the time, with Col. Bob Brannon. We were touring around Europe with our wives, having a gay old time. We hadn't listened to a radio or a TV in a few days. We'd come back up from Yugoslavia, and we'd stopped at Aviano Air Base, Italy, to try to get some quarters for the night, and to get some gasoline. Well, as soon as we hit the base, one of the dentists we knew over there recognized us. He said, "Hey, they've been looking for you guys." So we were immediately kind of put under house arrest and told to get your fannies back to Frankfurt because of this Beirut Marine disaster. So we had to cut our holiday short. Col. Brannon was attached to Wiesbaden Hospital at the time as the oral pathologist. I was attached to Wilford Hall, so I really didn't work for them. But I got requested to go along, and I spent a few days at the Rhein Main identification center. We didn't have much AFIP personnel involved with that at all. That was one mass disaster that we were kind of relieved of the responsibility for.

Following that one, the next one took a few years before it came about. But not many,

because in December of '85, that's when the Gander, Newfoundland, disaster occurred, with the 101st Airborne Division going from the Sinai region back to Ft. Campbell for Christmas. As you remember, that Arrow Airlines was a big DC-10 that, whether they admitted it or not, was overloaded. They had figured the average weight of the soldier, with gear, to be about 160 pounds, which was ridiculous.

*Q: Absolutely.*

**COL. HARTMAN:** With gear, these guys weighed well over 210 pounds per person. And they'd just taken on a full load of fuel. It was early in the morning, again, when the aircraft lifted off from the strip at Gander. It lifted, gained a little altitude, and just peeled over to the right, then came down and crashed, just short of a small lake up there. It hit the ground and skidded and came to rest in a big area that became known as the pit, where the bodies just forcefully went forward and hit the bulkhead. And about, oh, anywhere from six to eight layers of bodies were buried in this area called the pit. Of course, having that plane just refueled, there was a massive, massive fire, and almost all the victims were just totally burned.

I was chairman of the Department of Oral Pathology at the time and happened to be taking a forensic pathology course at the Smithsonian. And while we were down there, we heard the news report, and within an hour, why, we were on our way up to Dover to get ready for the identification exercise.

What happened that's of historical significance in the Jonestown disaster was that this was the first time that an automated, computer-assisted dental identification system was put into effect. Another Air Force colonel, who happened to be a general dentist, but he's also a forensic dentist, by the name of Bill Morlang, had developed, along with an Air Force programs computer specialist, a sorting and matching software program. Now that was used to some extent in Jonestown, and we used it a lot with the Gander incident. Most of the IDs can be done manually, but when you have large numbers, using a computer-assisted postmortem identification system takes a lot of the footwork for the dentist out.

You can well imagine, in Jonestown, with 913 sets of remains, you have to make up a dummy record on each one of those sets of remains. And you put tables out and then you lay the records down, right next to each other. Well, to make one lap around all of the tables in Jonestown, and if you left all 913 bodies out, if you spent just 30 seconds looking at each record, well, multiply that times 913, and you can see it takes hours to make a lap around the table.

With a computer-assisted program, obviously you don't rely upon the computer to make the exact identification. But what this program did for us, it would give us maybe five possibilities, maybe ten possibilities. That's better than looking at hundreds of possibilities.

*Q: Sure, absolutely.*

**COL. HARTMAN:** We would go to those records that the computer had differentially diagnosed for us, pull them out, bring up the X-rays, and you could make an ID much more expeditiously than doing it manually. Now this program has been further refined, and we have not used the newest version of the program in a mass disaster yet. We anticipate, with the

progress of our DNA identification, that it won't be long now, maybe by the end of the century, until DNA identifications will pretty much replace other forms of mass-disaster identification. You will still have the necessity for doing fingerprints, when they're available, and, of course, small numbers of dental identification. You'll never replace the need for fingerprints and dental ID, but in mass-disaster scenarios, I would think that DNA is going to greatly speed up the process, decrease the cost, decrease the number of personnel. And that's why we're building this DNA database, a repository for the Department of Defense. That's located here at the Institute now. It's part of our armed forces DNA identification program.

*Q: Each person gives a sample and you make a record?*

**COL. HARTMAN:** That's right. Our objective in this program is to take an antemortem sample, if you will, on every person who's on active duty. The recruits for the Army, we started in June of 1992. The Air Force has not come onboard yet, and the Navy has partially had some of their incoming recruits drawn. The whole program will not be totally financed until 1 October of this year. At that point, we will bring some of the Air Force recruits on, as well as the rest of the Navy recruits. In addition to the recruits, you've got the residual active-duty population to do. So we estimate it'll take us a good five years to sample everybody. But the beauty of that is you'll at least have an antemortem blood sample on these people in a local repository. If you have to do a remains identification, it's a fairly simple matter. In a postmortem set of remains, if you're totally incinerated, surely there's somewhere on you that we can find a small amount of soft tissue, and do genomic nuclear DNA typing on you, and compare it to your antemortem specimen.

This is another example of technology that's going to revolutionize some of the ways we do mass-disaster identifications.

*Q: Going back now to your time, you were here in this first period as a resident until when?*

**COL. HARTMAN:** The residency at AFIP started in July of '71, finished in July of '74. And then, in 1976, I stayed on as a staff oral pathologist. In 1976, Col Hooker became the new chairman. He appointed me chief of hard tissue oral pathology. We had two divisions, soft tissue and hard tissue, then. So I stayed until October of '77, and then I moved on to Keesler Air Force Base, in Mississippi. I spent 1977 until 1981 there, and was then transferred to Wilford Hall Medical Center, at Lackland Air Force Base, in San Antonio, Texas, where I served as department chairman of Oral Path. until April of 1984, when I came back here to be chairman at AFIP for Oral Path. I served my chairmanship here from April of '84 until March of '87, when I became an associate director for the Institute. And I've been in this capacity since March of 1987.

*Q: When you came back to the AFIP in '84, had you seen any change in the role of the AFIP since you'd left?*

**COL. HARTMAN:** No, I couldn't say I'd seen any remarkable changes. Business still was

pretty much as usual, and almost the same groups of people were still around. We still had Dr. Helwig, Dr. Enzinger, Dr. Mostofi, Dr. Irey. None of the crowd had really left, to any extent, yet. I could tell that the infrastructure had changed; there weren't as many people helping me get letters typed, or drawing slides out of the repository. That had changed in the few years I was gone.

*Q: Was the demand still the same with the referrals pretty much?*

**COL. HARTMAN:** Demand tended to be increasing. The numbers of cases got up to around 60,000 in 1985, and that was more cases than we were staffed to do. It became pretty difficult to have an acceptable turnaround time.

*Q: Did you see a correlation between the increasing number of cases and the growth of legal claims, malpractice and all this? Were you getting concerned that you were becoming sort of a protection against malpractice suits and all that?*

**COL. HARTMAN:** We received a few cases, but it's ordinarily the policy of this Institute that we don't accept cases that are in litigation. We purposely refuse to see those cases. However, a few cases get by the door. We typically only accept cases from pathologists; we don't accept cases sent in by lawyers or patients. They have to come through a pathologist, and as part of the submission routine, that pathologist has to sign a form, called a Form 288, which states, to the best of his knowledge, there's no litigation on the case that he's submitting for consultation. Now we do get involved in litigation, but I had not noticed any appreciable increase when I came back in '84.

In the oral cavity environs, there are mistakes made, just like there are in other areas. The most common mistake would be failure to diagnose, and then failure to treat in a timely fashion. Well, if a practitioner out there had sat back and watched a cancer of the tongue grow for a year or two before he decided to biopsy it, that's obviously a legitimate claim on the part of the patient, to try to get some remuneration for that. We would get, on occasion, a case like that, and at the time, we didn't know the patient was going to sue. At the time they had submitted it, there had been no intentions, as far as the pathologist knew, of anybody being sued. So, retroactively, the Institute has been drawn into a number of these claims cases.

We also serve to work with the Veterans Administration in reviewing VA claims cases, people who had served in the military and stated that a condition they developed was a result of active duty. They then apply for compensation through the VA system. And a few of those cases make their way over here for a decision from us.

*Q: Did Agent Orange intrude upon your particular field?*

**COL. HARTMAN:** No, it didn't bother oral pathology, but certainly Dr. Irey had quite a registry of Agent Orange going.

*Q: This was a defoliant used in Vietnam, which has been claimed to cause medical problems. It*



*has also become very much a political cause as well as a medical one.*

**COL. HARTMAN:** Yes, and you'll see something analogous coming out of Desert Storm, which you've already heard about, this mysterious condition where people feel disoriented, fatigued--a lot of vague symptoms that are difficult to tie together to say that it's an actual disease complex. Maybe it's not the same as Agent Orange; there was no chemical agent implicated that they've been able to identify. And perhaps it's psychologic. But in the minds of the people who are afflicted with this, it is a true malady, even though the scientists say there's no basis for this. When people think they have disease, then you have to do your best to make an attempt to identify it. I don't know that we'll be plagued so much with Desert Storm cases, but certainly we were involved heavily in getting Agent Orange cases. The Veterans Administration decided to shut down the Agent Orange Registry around 1986, but those cases are still in-house, though.

*Q: When you moved in to become one of the directors, you were now in the command structure of the AFIP. Was your perspective any different once you got in there? How did you find this place run and all?*

**COL. HARTMAN:** Yes, my perspective had changed. Having been here as a resident, of course, the more you stay around this place, the more you realize [tape end] ...the latter part of my career. And I thought this was a good chance to get some administrative experience.

Col. Robert McMeekin, the director at the time, was envisioning a large reorganization of the Institute. You probably know some of the facts about that. Col. McMeekin was really a visionary. The man had incredible vision. I wouldn't profess to have any of the abilities he has in being creative about management structure. He formed a task force, and many of us served on this task force. We met two or three times a week for a period of months, and we came up with grandiose ideas about how the Institute should be separated, in terms of dividing up departments, merging departments, just in general changing the way this place operated. On paper, boy, it was a daring plan.

Many of the staff who weren't part of the working group that was going to make these changes were informed the best we could keep people informed, so that there wouldn't be any surprises, but I don't think the majority of the staff liked the idea that there were going to be some changes made. As you well know, people always resist change.

*Q: Oh, absolutely.*

**COL. HARTMAN:** They were afraid that the Institute was going down the wrong path and this would be a disaster.

What came out of the original plan was not nearly as the plan had been designed. It was a very scaled-down version of what we all had gotten together and brainstormed over. The changes that we had proposed would have been easy to do if we'd had a new building to move into. But when you're talking about people who have been in a geographic region of this building for forty years, and trying to get them to buy into a plan where they give up half of their space to another department, it would have been chaos if that plan had been implemented, at least it

would have been, in my mind. I just didn't think that the director could pull this off; it just wasn't sellable.

And that is how it came out. We made some fairly major changes in the senior-management levels, and we did merge some departments and things like that, but we didn't do a lot of displacing of departments. We had some of that going on.

This original plan that Dr. McMeekin had envisioned, had he been allowed to stay on, I think we would have made more changes than we eventually ended up making.

*Q: Did he leave more or less under pressure, or how did that work?*

**COL. HARTMAN:** The assistant secretary of defense for health affairs, Dr. Bud Mayer, decided it was time to move Dr. McMeekin into another position, and he was sent downtown to the FAA (Federal Aviation Administration), where he became an administrator for the medical aspects of the FAA, even though he was active-duty military. Following Dr. McMeekin's departure, Dr. Karnei became the next director. And, of course, every director has his own ideas about how a place should be structured, organized, and administered. Now Dr. Karnei had been part of the directorate under Dr. McMeekin, he was familiar with the plan, and I know he thought several aspects of it were quite good. But he also realized the great difficulties that would have resulted had you tried to push this thing, in its totality, upon the staff. It just couldn't be done in the existing space that we had.

I still think there's adequate reason to merge some departments, so that you'd have more depth of staff. We have 22 subspecialty departments. Some of these departments have two or three people in them. If one person dies, retires, leaves, you've got no depth of expertise in that department. It's marvelous to say we've got all of these subspecialty departments, but it's a bear, as a manager, to keep them staffed with competent expertise. Let's say you merged Hepatic and GI, which we did. That's been one of our successful department mergers. Well, Liver and Gastrointestinal Diseases often go hand in hand together. It's easier to cross-train the pathologist into those two areas. It makes it a little more interesting for your junior staff; they don't get stuck with tunnel vision in the one area. So I think more of that is coming as we experience some downsizing due to military cuts and civilian loss of authorizations. I personally think amalgamation of a few more departments is going to have to occur.

*Q: As you were looking at this, from the management point of view, were you finding that these departments, which, for an outsider, resemble little dukedoms here, that some dukedoms were responding to the referrals, and other ones were letting them pile high? There may have been technical reasons why: some cases you can just whip right out, and other cases require a lot of looking at. But did you find that there was an unevenness here that was a problem?*

**COL. HARTMAN:** Oh, yes. As you mentioned, there were certain departments where it may have taken months to get out a diagnosis. Not on every case, but they would drag their feet on signing-out some cases.

Now under the reorganization that Dr. McMeekin originally envisioned, we started taking cases out of departments, we started improving turnaround time. And I would say that was the

great benefit out of this change in the management structure: we suddenly started paying more attention to our customers, the contributors out there. In the best interest of patient care, most departments had always tried to turn cases around as fast as they could. But the stimulus, the impetus, still wasn't there until we had the reorganization.

That's been part of the difficulty that Dr. Mullick, the other associate director, and I have had, trying to make people time-responsible.

The next thing that came along, which speeded this process up, was the American Registry of Pathology's (ARP) collaborative program with us that we would start charging a nominal fee for civilian consultation cases. Well, now, if you want to be competitive in the civilian consultation business, you'd better have a respectable turnaround time. And through the collaborative efforts of both ARP and the AFIP, we developed the system in '88 and '89, and then, more recently, we started the charging process, I think, in 1990. As a result of that, our turnaround time went from weeks down to days, and for a while there, we were able to turn around routine cases that didn't require lab work...the policy is, in 72 hours, we would have a case going out the door here into the mail. We FAX; we make a lot of phone calls. And this system has done a lot to enhance our credibility in the medical community. And we try to treat military cases just as we do civilian cases, even though there's no fee for federal cases.

So I would say, overall, as a result of that reorganization, the Institute benefitted from the standpoint of paying attention to turnaround time. That, to me, was the major thing that came out of it.

*Q: Here you are, you're one of the directors. Are there parts of the McMeekin Plan and the McMeekin-Plus Plans that are still in the works, trying to bring this organization into what you consider a more efficient one?*

**COL. HARTMAN:** There will be some changes, of course, when I retire February 1, 1994. We will be down to one associate director, Dr. Florabel Mullick. And Dr. Mullick will be tasked with some reorganization. I have the largest departments, in terms of surgical pathology. I have ten departments, she has twelve. The departments I manage do about 76 percent of the consultation cases; her departments are more research oriented. So when one person has the span of control of all of these departments, there's going to have to be a little more reorganization. I think Dr. Mullick will have to make some changes, because she will have limited manpower--essentially herself and some administrative staff--to help her. It's going to be a huge task for her to do most of this by herself.

If I were in her position, I probably wouldn't do it the same way as you would or she would. In my own mind, I would make attempts to merge a couple of departments, to try to get an increased staff, increased depth of experience, and try to build some succession in the departments. As people retire who have been here for thirty or forty years, you don't replace experience like that in a short period of time. And as they do retire, it leaves a huge gap in your ability to carry on pathology in a given subspecialty area.

You have to have civilians in departments for stability. You cannot have all military staff and run a consultative institute; it just simply doesn't work, because the military moves people around. At the point you begin to get competent, maybe somebody'll decide it's time for you to

move on. So, civilians are the backbone of this institution; you've got to have them. And, quite frankly, we don't have enough civilian pathologists anymore. We need several more.

The way surgical pathology is changing, as we alluded to earlier, with what's happening in molecular biology, it's going to be difficult to continue practicing surgical pathology, as we know it, at this Institute. It's going to have to change, because of limitations of, principally, resources.

I've been very pleased with the management that I've seen since I've become associate director. We've had strong management in this institution. The people comprising the Executive Committee, a very dedicated group of people. Nobody in the building works harder than the people comprising the Executive Committee. And, of course, they should; they have the responsibility of making this place work. So we take that charge very seriously.

I, quite frankly, am looking forward to retirement, though. I don't have any hesitation about saying that I think retirement will be another phase of life which will be quite enjoyable. I've enjoyed this phase, but it's time to move to another phase now.

*Q: One further question. Everything in Washington is politics. Does the AFIP have good backing from both Congress and from the Defense Department? At various stages that you've seen it, have you seen a change?*

**COL. HARTMAN:** Oh, I think there has been a definite change. I would say that with the advent of Dr. Mayer, when he was assistant secretary of defense for health affairs, the AFIP began getting a little more political emphasis. Dr. Mayer came out here on a number of occasions. He chaired the Board of Governors, which met every three months. And to have somebody at the level of assistant secretary of defense, it's a fairly high political level.

And when Dr. Mendez replaced Dr. Mayer as the assistant secretary of defense for health affairs, Dr. Mendez had tremendous impact upon the Institute. This man is another true visionary. He also is a person who can take extremely complex structural things and make them very simple, and he can sell programs to people. The man has incredible presence and charisma. He's one of the best people-motivators I've ever met in my life. And I think Dr. Mendez just did a magnificent job as the ASD in promoting this little jewel. This man just did the greatest job of promoting the importance of AFIP, not just to the military medical community, but to the civilian medical community. Eventually, towards the end of his tenure, he was given control over the budgets of the three military surgeons general. That gave him tremendous power, and I think he used that power very wisely to point out to his surgeons general that there are elements that you people are staffing, that you support budgetwise, and AFIP is one of those elements that you need to pay continued attention to, because the type of work that this little institution does is not duplicated anywhere else in the civilian or government sector. We have done some amazing responses to problems, on very short notice. Being small gives us the ability to do that. And Dr. Mendez received proposals that we would make. For example, our Department of Defense DNA program would not have happened, would not have gone anywhere had it not been for the vision of Dr. Mendez. He did the same with the AIDS pathology registry. He's done the same for a number of our medical examiner issues. The Armed Forces Medical Examiner system, again, is a result of Dr. Mendez supporting initiatives like this. He has done more, in my mind, than any

predecessor has ever done, in my career, to promote the interests of this institution. ..

*Q: I interviewed him yesterday, and he spoke with great fondness about the AFIP.*

**COL. HARTMAN:** I believe he really loves the AFIP.

*Q: Oh, yes.*

**COL. HARTMAN:** I really think he does. He never missed a Board of Governors' meeting. He had an impeccable record when it came to taking charge of these meetings. He never sent a substitute; he was always here. That really attests to the mission that this man felt this place was responsible for.

*Q: Well, doctor, is there anything else?*

**COL. HARTMAN:** Well, I did want to make some remarks about some of the early chairpeople for the Department of Oral Pathology.

Col. Joseph L. Bernier was the first chairman of the Department of Oral Path. I think he was chairman between the years 1949 to 1960. Long tenure as chairman; in fact, he was appointed by Col. Ash. Gen. Bernier had a habit of, when he came somewhere, just sort of occupying things and not leaving. I was told by reputable people who were here when they opened this new building that Joe, as they like to refer to him, just put books and desk and chairs in, and occupied about half of the third floor--he was calling this his territory for the Department of Oral Pathology. Well, some of his counterparts got a little upset and they downsized Gen. Bernier's plans for his department. He eventually ended up with a very fair share of the property. And when it came time for him to leave, when he was promoted to major general to become chief of the Army Dental Corps, he wouldn't move his stuff out of here.

The second chairman was a Navy captain by the name of Louis Hansen. And Lou Hansen was a very patient man, but he had reached the point of tolerance where he said, "Gen. Bernier, if you don't get your stuff out of here, I'm going to move it out bodily." Gen. Bernier did nothing about it--what's this lowly O6 talking to an O8 like that for? But Lou Hansen lived up to his words. He moved Gen. Bernier's stuff--books, belongings, slides, everything--right out in the hall. And then Lou Hansen moved into the office that Gen. Bernier had occupied. Finally, Gen. Bernier sent some people by to pick up his stuff and get it out of the way of the department. Lou Hansen was chairman from 1960 to '63.

He was followed by another Navy captain, by the name of Henry Scofield, from '63 to '65.

The Air Force had its first turn, from '65 to '69, with Col. Bill Sprague. Kind of an unforgettable character. Huge fellow, 6 foot 7, giant of a man. And loved to bully people. I can remember, as a resident, him looking down at me. He was gone from here, but he would come back and visit us and have special sessions with the residents. And myself only being 5'8, and him, about 6'7, he loved to look down on you. And he had a big, hawklike nose. He could instill quite a bit of fear. It was not pleasant being dressed-down by Col. Sprague.

Col. Robert Boyers, from the Army, was chairman from '69 to '73, and he was the leader of the department when I came in '71. Beautiful little man. It was like Mutt and Jeff, seeing Sprague and Boyers. Boyers was about 5'2 or 3, but a beautiful person.

He was followed by a Navy captain by the name of Seymour Hoffman, from '73 to '76.

Col. Southern P. Hooker, whom I related earlier, was chair from '76 to '79. Another interesting sidepoint about Col. Hooker was that he was a descendant of Gen. Joe Hooker, of Civil War fame.

*Q: Oh, yes, "Fighting Joe" Hooker.*

**COL. HARTMAN:** "Fighting Joe," that's the one.

*Q: Chancellorsville.*

**COL. HARTMAN:** That's right. And while Southern was here, he had the opportunity to go down to the National Archives and see the original letter of reprimand that President Lincoln had given Gen. Joe for one of his foul-ups. I guess it may have related to one of the battles; I don't know.

But, anyway, the term "hooker" was derived from "Fighting Joe's" girls, the camp girls that used to follow his army around. He had to be a great general, because he realized the troops needed something to do in their off-duty time, so he permitted these ladies-of-the-night and their wagons to follow his troops around. They became known as "Joe's girls," "Hooker's girls," and eventually the term shortened to the vernacular of just "hooker."

Southern P. used to tell his audiences, when he'd go out and lecture to dental societies and other groups, that you better not tell your wife tonight that you spent the evening with a happy hooker. He had quite a sense of humor.

As I mentioned, we were indebted to Southern P. for his development of mass-disaster dental identification.

The Army followed with Col. Jim Adrian, '79 to '81.

Navy captain, Russell Corio, '81 to '83.

I came along from '84 to '87.

Brent Kadelka, Army colonel, from 1987 to 1990.

The current chairman is a Navy captain by the name of Paul Auclair. He'll serve from 1990 to '93.

Our next chairman will be Air Force again, Col. Bob Brannon, and he'll take the reins from '93 to '96.

One unusual thing about the Department of Oral Pathology is that we rotate the chair amongst the three services. Every three years, we change service chairpeople, somewhat like the Institute does for the directorate. They rotate every four; we rotate every three. It's the only department that does that in the building, so it makes us unique from several standpoints.

I would say that one of the strongest departments in this institution is and has been the Department of Oral Pathology. They've contributed a lot to the science of tumors and diseases, especially of the head and neck region. The current chairman, Dr. Auclair, and his staff have

made some outstanding publications in the last couple of years, textbooks, and they're currently working on a new fascicle for the American Registry of Path.

So I only see a strong department staying up there. Dentists tend to be quite compulsive people. They aren't necessarily the brightest people in the world, but they're some of the hardest-working people in the world. And I think, because of their perseverance and their compulsive nature, which make them go into dentistry, they tend to take on projects, and they finish them, in an acceptable time period, usually.

I would like to thank you for the opportunity to say something about oral pathology and recount some things in my career. I found this to be quite rewarding for me, and I hope that, someday, when the history is written about the AFIP, they'll mention oral pathology.

*Q: Well, I'm sure they will. Thank you very much.*

**COL. HARTMAN:** Okay, Mr. Kennedy.